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## Ageing, vulnerability and care: a view from social gerontology

### *Introduction*

In this chapter the focus is on the relationship between ageing and care to examine what is distinctive about needs in later life at this point in time and to discuss the range of factors that shape need and perceptions of need in old age. It is argued that the risks and limitations associated with later life are not only intrinsic to the individual but also constituted by prevailing cultural values, expressed in practices of care. Of itself, age categorization, an enduring feature of British welfare services, plays a part in shaping perceptions of old age and older people's moral claims for care. Old age has a long established association with vulnerability, but the nature of this varies. At this point in time, reliance on publicly funded services in later life produces particular forms of precariousness.

In the UK as elsewhere, societal ageing is associated with a number of different trends, including reductions in fertility and mortality rates as well as extended life expectancy. The perception that an ageing society represents a burden is well entrenched in policy-making, although there are competing narratives concerning the best way to respond. Based on simple extrapolation from current service utilisation by people aged 65 and over, predictions of future needs for care present an alarming picture concerning the affordability of health and social care services. Policy-makers' attention is focused on ways to *reduce demand* and *cut costs*. At the same time, older people's organisations call for attention to those who, despite their evident needs, receive no support and to those within the care system whose rights have been seriously undermined<sup>1</sup>. These different perspectives raise deep moral and ethical questions about the way in which a society supports its people when they are in need. In this chapter the focus is primarily on the social care system, which at the time of writing is in a state of crisis that has stimulated controversy over intergenerational relations and raised questions about the allocation of responsibility for the care of older people. Discussion of these questions inevitably involves revisiting the debates concerning the relationship between public and private realms of care.

### *Longer life, changing needs*

Increasing life expectancy at all ages has been a dramatic feature of the past century. Life expectancy at birth is now double what it was in the middle of the 19<sup>th</sup> century and there is a similarly dramatic trend in life expectancy at older ages. At age 65, men can now expect to live for a further 18.8 years and women for a further 21.2 years, approximately double the expectancy of the early twentieth century. Socioeconomic inequalities in life expectancy are stark, with men in Kensington and Chelsea having a life expectancy at age 65 21.6 years compared with 15.9 in Manchester. For women at age 65, life expectancy was highest in Camden (24.6 years) and lowest in Manchester (18.8 years)<sup>2</sup>.

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<sup>1</sup> See, for example, the Policy Briefing by Age UK *The Health and Care of Older People in England, February 2017*

<sup>2</sup> Office for National Statistical Bulletin Life Expectancy at Birth and at Age 65 by Local Areas in England and Wales: 2012 to 2014 released 4th November 2015.

There is a related trend in age at death. In 2013, the majority of all deaths in the UK were of people aged 80 and over (46% men and 63% women), while deaths below the age of 60 accounted for only 14% of all male deaths and 9% of all female deaths. These figures compare vividly with those at the turn of the twentieth century, when deaths over the age of 60 accounted for approximately a quarter of all deaths. At this point in history, therefore, old age is more strongly linked to death than at any time in human history, a linkage that has significant social and cultural consequences. The expectation of a long life is now deeply embedded in cultural norms and premature deaths are widely regarded as unnatural, unfair and requiring explanation.

The added years of life are not an unqualified benefit, however. Typically they are spent with long-term illnesses, some of which affect people's mobility and thus their everyday life and activities. Current figures<sup>3</sup> for England show a difference of 15.7 years between men's average life expectancy of 79.2 years and healthy life expectancy of 63.5 years, while the equivalent for women is 18.2 years difference between average life expectancy of 83 years and healthy life expectancy of 64.8 years (thus 18.2 years spent 'not in good health'). Long-term illnesses are not always disabling and evidence suggests that a high proportion of older people remain independent to a very old age.<sup>4</sup> There are, however, growing numbers of older people whose health conditions are disabling. The 2001 UK census revealed that over 50% of the population aged 75 and over had at least one limiting long-standing illness. Figures for disabling illness in later life reflect a sharp socioeconomic gradient. Figures for England published in 2016 show a five-fold difference between the local authority areas with the lowest and the highest disability free life expectancy after the age of 65.<sup>5</sup> These socioeconomic differences in later life have usually accumulated over the life course. Health in later life thus reflects a complex mix of causal factors.

Action to replace the discourse of illness and decline with a more positive and active view of ageing has been supported by the World Health Organisation (WHO) and reflected in diverse strategies developed by governments around the world. In the words of the WHO these strategies are about 'adding life to years, not merely years to life'. They are many and diverse and encompass the promotion of healthy lifestyles in later life as well as engagement in social and community life and continuation of paid employment past retirement age. In policy terms, active ageing strategies have also provided a focus for delaying age-related illness and maximizing people's capacity for independent living, as evident in this extract from a UK government policy paper<sup>6</sup>

*'We see retirement as an increasingly active phase of life where people:*

- have opportunities to continue contributing to society by working longer or volunteering in their communities*
- take personal responsibility for their own wellbeing by working, saving and looking after their health'*

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<sup>3</sup> 'Healthy Life Expectancy at Birth and at Age 65: Clinical Commissioning Groups (2010-12)', Office for National Statistics, 2014.

<sup>4</sup> See for example the Newcastle 85+ study: <http://research.ncl.ac.uk/85plus/>

<sup>5</sup> Office for National Statistics (2016); " – "Disability-free life expectancy (DFLE) and life expectancy (LE) at age 65 by upper tier local authority," England

<sup>6</sup> 2010-2015 Government Policy: Older People Department of Work and Pensions 8<sup>th</sup> May 2015

Ideas about ‘active ageing’ have been influential within gerontology, also. In 1987 Peter Laslett published ‘*The emergence of the third age*’<sup>7</sup>, in which he argued that the post retirement years should be seen not as the beginning of a period of decline but as a period of activity and opportunity in which new forms of leisure and personal-growth become possible, when individuals with occupational pensions are freed from the shackles of work. The concept of the third age unsettled traditional ideas about ageing<sup>8</sup>, although critiques have subsequently been developed, which point to its limitations. The quotation above from a British government policy paper demonstrates how the ideal of active ageing can be adapted by policy makers to emphasise values that are consistent with a wider political agenda – in this case the promotion of individual responsibility above pooled risk in welfare. Moreover, as Julia Twigg has argued, it is only possible to have a third age by projecting into a ‘fourth age’ all the problems and difficulties associated with ageing<sup>9</sup>. A binary distinction between the active, healthy and zestful old on the one hand and the frail, unhealthy and dependent old on the other runs the risk of marginalising the latter group. Evidence suggests that, in retrospect, some older people can identify a time, almost invariably coinciding with bereavement and/or significant changes in health, when their lives changed and they began to ‘become old’. Others experience a more gradual change and perceive themselves as ‘slowing down’.<sup>10</sup> The influence of wider sociocultural values must also be taken into account when considering subjective interpretations of ageing,<sup>11</sup> how older people adjust to their changing physiological state and make decisions about whether or not to seek assistance with everyday tasks. True, old age is not all about decline and illness, but decline and illness are an inevitable part of old age. There are therefore good reasons to perceive support as a social rather than an individual social responsibility. Otherwise, those with limiting health conditions run the risk of being perceived as having failed when they seek social support.

### *Dependency and the need for care in later life*

The complexity of older people’s experiences of long-term illness is exemplified in studies of frailty.<sup>12</sup> There are different perspectives on the causes and definitions of frailty but currently, the emphasis is on refining medical knowledge and improving practitioners’ recognition of the signs or indicators. This improved knowledge is seen as essential for better decision-making about the efficacy of medical interventions as well as the efficient targeting of public resources. In practice, identification of frailty has been problematic. Gilleard and Higgs, for example, argue that whatever the methods and advantages of improved assessment and diagnosis, frailty has come to signify ‘personal marginality and vulnerability’. The concept of frailty emphasises the deficits in a person’s health – a ‘diagnosis’ depends on an accumulation of deficits - and comes to mean all there is to know about a person<sup>13</sup>. It means

<sup>7</sup> Laslett, P. ‘The emergence of the Third Age’, *Ageing and Society*, Vol 7: 133-160, 1987.

<sup>8</sup> See for example Minichiello, V. and I Coulson (eds) *Contemporary Issues in Gerontology: promoting positive ageing*, London, Routledge, 2005.

<sup>9</sup> Twigg, J. *The Body in Health and Social Care*, Basingstoke, Macmillan 2006.

<sup>10</sup> Lloyd, L. et al ‘Identity in the fourth age: perseverance, adaptation and maintaining dignity’ *Ageing and Society* 34(01) 1 – 19 2014 DOI: 10.1017/S0144686X12000761

<sup>11</sup> Grenier, A. *Transitions and the Lifecourse: challenging the constructions of ‘growing old’*. Bristol, The Policy Press, 2012.

<sup>12</sup> Grenier, A. ‘Constructions of frailty in the English language, care practice and the lived experience’, *Ageing and Society* 27(3) 425–45, 2007.

<sup>13</sup> Nicholson, C., A. Gordon and A. Tinker ‘Changing the way “we” view and talk about frailty’. *Age and Ageing* 0: 1-3, 2016.

that health and social care professionals know only what an individual *cannot* do rather than what they *can* do and bears the risk that the individual will be seen as beyond help. Older people resist being labelled frail for this reason and because it they see it as a sign that an individual has given up the struggle to maintain health. There is, therefore, a deeply moral dimension to frailty in old age, the significance of which is not widely recognised in policy-making or professional practice.

Dementia carries particular risks, especially in the advanced stages when people's personhood is called into question. The loss of citizen rights becomes more all the more likely in these circumstances, because the individual is regarded as beyond redemption or restoration to 'normal' independent life. Indeed, it has been argued that when an individual's ability to articulate their needs and preferences has diminished because of dementia, professionals are released from responsibility for understanding what these are.<sup>14 15</sup> Jaworska, for example, points to evidence that people with dementia continue to have a *capacity to value* and that this should be distinguished from their loss of cognitive capacity<sup>16</sup>. Such a distinction would improve understanding of people's preferences and wellbeing and could transform their experience of dementia. She also argues that better recognition of the capacity to value could change perceptions of dementia more widely. A related point is the distinction between cognitive and practical knowledge<sup>17</sup>. For example, care home residents with dementia can often continue to do the things they are accustomed to doing, such as peel vegetables with sharp knives or boil water to make tea. The priority given to safety and protection in care systems, however, frequently overrides their ability to do things regarded as risky. Given contemporary legal and insurance contexts this is understandable but the effect is to diminish the quality of life of people with dementia and to exacerbate their dependency.

The ethics of care perspective<sup>18</sup> provides a useful framework for understanding the complex picture of health, illness and the need for support in later life. A fundamental tenet of this is that dependency should be understood as integral to human life at all ages but that it varies at different points in the life course. At the present time in the UK, it is in *old* age that the ultimate vulnerability of the human being – our mortality – is usually manifested. For the majority, it is in old age that our greatest need for support and care is most likely to occur – usually in the months and years preceding death. The ethics of care perspective places vulnerability in later life in the context of a whole life course and into the social and historical contexts that shape the conditions of vulnerability.

Joan Tronto describes her four stage model for an ethic of care – attentiveness, responsibility, competence and responsiveness – as *political*. She points to the false dichotomy between the moral and political domains to argue that moral claims, such as the right to be cared for when

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<sup>14</sup> Kontos, P. 'Embodied selfhood in Alzheimer's disease: Rethinking person-centred care', *Dementia*, 4, 4, 533–70, 2005.

<sup>15</sup> Adams, T and P. Gardiner, 'Communication and interaction within dementia care triads: Developing a theory for relationship-centred care'. *Dementia*, 4(2):185-205, 2005.

<sup>16</sup> Jaworska, A. 'Respecting the margins of agency: Alzheimer's patients and the capacity to value', *Philosophy and Public Affairs*, 28 (2): 105–38, 1999.

<sup>17</sup> See a discussion of this point in Lloyd, L. 'Understanding the fourth age' in J. Twigg and W. Martin (eds) *The Routledge Handbook of Cultural Gerontology*, Abingdon, Routledge 2015.

<sup>18</sup> See Marion Barnes *Care in Everyday Life: An ethic of care in practice*. Bristol, the Policy Press, 2012 and Joan Tronto, *Moral Boundaries: A Political Argument for an Ethic of Care*. New York, Routledge 1993

in need, cannot be separated from the political processes through which rights are realised in practice. She highlights the link between resources and competence in care – an extremely pertinent point in the current context of health and social care in the UK, when concerns are raised about diminishing standards of services concurrent with cuts in expenditure.

Nevertheless, a critique of the feminist ethics of care is that it lends itself more easily to analyses of policies and practices of care than to the broader social and political determinants of vulnerability that contribute to the need for care. Grenier, Lloyd and Phillipson<sup>19</sup>, drew on Judith Butler's analysis of the precarious life<sup>20</sup> in their examination of dementia. Like Tronto, Butler argues that all human life should be understood as precarious but her focus is on the ways in which life is rendered *more* precarious for particular groups and populations whose lives are perceived as low value. These include refugees, migrants, low-waged workers and welfare recipients of all ages. From this perspective it is possible to discern what vulnerable people of different ages share in terms of their devalued social status, to distinguish more clearly between existential and contingent factors that influence ageing and how particular historical locations shape conditions of precariousness.

The next section of this chapter looks in greater depth at the ways in which policies designed to support older people can have the effect of exacerbating their precarious position. It draws together evidence on the contingent limitations of ageing and the particular conditions that exist today, which blur the boundaries between the private and public spheres of care.

### *Crisis in the market for care*

A century ago, according to Lloyd George, old age was one of the 'spectres' that haunted the poor and a core aim of social policies ever since his 2008 Old Age Pensions Act has been to banish this spectre. In 2017, a report by the Fiscal Studies Institute<sup>21</sup> estimated that the median income of pensioners is now £9 per week higher than the median income of the working aged population. Rather than being hailed as a policy success story, however, the relative wealth of older age cohorts is frequently framed in terms of the potentially damaging effect of this kind of intergenerational inequality. For the old to be relatively well-off goes against the grain of long-standing perceptions of old age, as a time of relative poverty. A twist to this perception is that the old have improved their position at the expense of the young. Thus, David Willetts argued that '*the baby boomers have concentrated wealth in the hands of their own generation*'.<sup>22</sup> In the space of a century, the 'needy old' have become the 'greedy old'. The circulation of such ideas in the context of policy-making plays an important part in shaping public perceptions of ageing and contributing to a new form of negative stereotype of later life. The 'needy old' have not disappeared from the picture. The Joseph Rowntree Foundation<sup>23</sup> estimates that 1 in 6 pensioners live below the poverty line (that is, an income below 60% of the contemporary median household income).

An underpinning theme of the contemporary policy context is that increasing numbers of older people represent an economic burden and that health and social care will become

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<sup>19</sup> Grenier, A. Lloyd, L. and Phillipson, C. 'Precarity in late life: rethinking dementia as a "fraild" old age'. *Sociology of Health and Illness* 39 (2) pp. 318–330, 2017

<sup>20</sup> Butler, J. (2006) *Precarious Life: The Powers of Mourning and Violence*. London: Verso.

<sup>21</sup> Fiscal Studies Institute, 2017

<sup>22</sup> D. Willetts *The Pinch: How the Baby Boomers Took Their Children's Future - And Why They Should Give It Back*. Atlantic Books 2010

<sup>23</sup> <http://www.jrf.org.uk/data>

unaffordable.<sup>24</sup> Dependency ratios, which reflect the proportion of a population of working age to those above or below that age, provide a rough and ready measure of the relationship between income tax revenue and welfare expenditure. They are open to criticism because they overlook tax revenues on pensions as well as continued economic activity beyond retirement age and because they fail to acknowledge the productivity of unpaid work, such as volunteering and unpaid care. A European study, for example, revealed that over 40% of grandparents provided child care that enabled parents to work.<sup>25</sup> Nevertheless, the perception of increasing numbers of older people as burdensome is well entrenched. The current overarching policy context of austerity has had particular impacts on the market system of care services for older people and generated new forms of risk and precariousness.

The market model that has dominated social care services since the 1990s has redefined care as a commodity to be commissioned by local authorities, or purchased by individual consumers, from a range of independent providers in the form of measurable tasks and time slots. Over the same time, need has become strongly linked to the loss of functional health, the ability to get in and out of bed, get dressed, wash, eat and use the lavatory are identifiable as need. The process of needs assessment produces an account of an individual's 'eligible' needs, which in turn becomes the basis of a transaction and a contract. The market system, coupled with the bureaucratic process of assessment, has produced an impoverished understanding of need and care to the aspects that can be measured. The current context of austerity and the associated squeeze on eligibility impoverishes this understanding yet further by redefining specific needs as 'non-essential'. An example from experience is where an individual who can stand at a basin and wash is not considered to need help to have a bath. In 2011, the Equalities and Human Rights Commission (EHRC) Inquiry into Home Care<sup>26</sup> concluded that the cuts in care services for people in their own homes had amounted to neglect. Six more years of austerity budgets have deepened the crisis, generating more cuts to services affecting more people and calling into question the potential effectiveness of the 2014 Care Act. The Association of Directors of Adult Social Services (ADASS) recently reported that funding for social care simply does not match growing needs for and costs of care and that the effects of this mismatch (referred to as the 'social care gap') is being felt by increasing numbers of people. The effects of crisis in social care have spread to health care ('bed-blocking' by older people in hospitals because of no suitable alternative places of care) and to families, who have been obliged to take on yet more responsibilities for caring for older relatives. The neglect of older people within the British care system exemplifies the point above that political practices cannot be separated from the moral agenda of rights. The theoretical right of vulnerable people not to be neglected has been, in some localities, almost totally eclipsed by the political priority of cutting the cost of welfare.

A question that arises from the above discussion concerns the extent to which the social care gap is the consequence of demographic trends. The answer is complex and multi-factorial and draws attention to the supply side as well as demand side. This is not to suggest that

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<sup>24</sup> See for example, the article 'Age Invaders', The Economist 24th June 2014

<sup>25</sup> 'Grandparenting in Europe: family policy and grandparents' role in providing childcare', K. Glaser, et al. Grandparents Plus, London 2013.

<sup>26</sup> Equalities and Human Rights Commission *Close to Home: Inquiry into Older People and Human Rights in Home Care*, London, ECHR [www.equalityhumanrights.com/homecareinquiry](http://www.equalityhumanrights.com/homecareinquiry) 2011

demographic trends have no impact on demand but to consider the bigger picture. For example, the Local Government Association's Adult Social Care Funding: 2016 State of the Nation Report, points to cost pressures arising from general inflation and increases in core costs, such as national insurance, the national living wage and pension contributions, all of which have arisen in the context of a 40% reduction in real terms in their core government grant. There is also a wide range of influences on demand<sup>27</sup>. These include the health status of older people, their income, the suitability and accessibility of services as well as technological developments. Another set of factors relates to age at mortality. Evidence suggests that it is not age *per se* but proximity to death that increases the individual's need for health care<sup>28</sup>. Current policies encourage care homes to provide for residents to die *in situ* rather than being transferred to hospital to die, which has an impact on social care spending.

The crisis in social care affects not only service users but also providers. In the 2016 ADASS budget report cited above it is claimed that the continuity of the care market is currently under threat because of the increased risk of provider failure. Currently, local authorities are grappling with the effects of closures of independent home care agencies and care homes. Providers point to central and local government policies as the reasons behind these closures – most particularly, the introduction of the living wage by central government and the stagnation of local authority payments for commissioned services. These policies have created tensions in the relationships between the state and commercial providers. Reluctant to impose heavier regulations on providers, the government has instructed local authorities to be alert to the possibility of service provider failure (regarded by them as a normal and acceptable aspect of any market) and to be ready to act to protect service users if it should occur. The network of relationships between central and local government, service providers, older people and their families has become entangled, as the policy aims of reduction of the cost of social care services and the promotion of care markets have collided. The crisis has shown in stark relief the weaknesses of a market model and the precarious conditions it generates for older people, care workers and family carers.

For example, the continuing emphasis on the provision of services in people's own homes carries particular risks related to the protection of their rights. The 2014 Care Act (section 73) has extended the rights of people who receive domiciliary services from private care providers under contract with the local authority. Independent care providers are now regarded as exercising 'functions of a public nature' and must respect ECHR rights, such as those associated with Article 8 ECHR (respect for private and family life). This extension does not, however, cover the increasing numbers of people who purchase personal care services independently.

Within the care system, family carers have secured greater recognition and right of parity with the people they care for in their entitlements to assessments of need and access to support services. There is greater recognition of the value of the work carers do, which in monetary terms, according to Carers UK, is £132 billion a year. Under the 2014 Care Act local authorities are encouraged to provide free support to carers on the understanding that

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<sup>27</sup> See Appleby, J. *Spending on health and social care over the next 50 years. Why think long term?* The King's fund 2013

<sup>28</sup> Seshamani and Gray (2004)



that there is a sound economic rationale for doing so.<sup>29</sup> Yet, under conditions of austerity, support provided to carers has been calculated in terms of what it *costs* the public purse rather than what it saves. Some local authorities have concluded that because of the severe constraints on their resources they must introduce charges for carer support. This would mean that carers will be paying from their own resources to save public resources through their unpaid care.

The current crisis in social care has raised deep questions about responsibility for care. In a recent representation to the government, the ADASS urged the government to engage in a ‘radical reconsideration of how to incentivise family and other informal carers’ and to revisit ‘the roles of the individual, family, community and the state’ to consider all funding options. The Minister for Communities, Health and Care, David Mowat, argued that people should ‘*start thinking about how we look after our parents*’, a phrase that reveals a lot about how older people are regarded as passive recipients who have nothing to contribute to the debate.

### *The public/private divide of care: blurred boundaries*

The boundary between the public (formal) and private (family) realms of care has never been crystal clear but contemporary conditions have caused it to be blurred in new ways. As budgets for care become more stretched and there is a reduction of provision, the pressure is felt by families and by front line care workers to take on more caring tasks, including more complex tasks. At the same time, there are increased demands for emotional labour from paid care workers. Arlie Hochschild has commented that since her seminal work *The Managed Heart* was published in 1983, new types of service role in the care sector have merged in the realm between home and work, which she has termed ‘marketized private life’. This description applies aptly to the situation of personal assistants employed by older people to provide personal support. For those who can afford it, employing a live-in carer offers a positive alternative to moving to a care home. Live-in carers are expected to provide not only personal care but also companionship and sensitivity to the older person’s wishes. The website of one employing organisation described it as follows: ‘*It takes a special kind of person to be a live-in carer. A good carer is someone who truly cares about others and is not just earning a living. This is a special job, and it needs special people to do it*’. There are no reliable data on the numbers of people employed in this way, the terms and conditions under which they are employed nor how many of them are migrant workers. In this private, home-based sphere there is little regulation of employment practices and, as discussed above, the ECHR protections applied to people whose care is organised through the local authority do not apply to those who make their own arrangements.

Tensions concerning the regulation of care provided in people’s own homes are reflected also in the use of observational technologies, which affect older people and paid care workers. Some technologies have facilitated ever more intrusive monitoring of older people’s private lives, extending into the areas of the home that would previously have been considered the most private – the bedroom and the bathroom. **Mortensen, Sixsmith**, discuss how the use of technologies has been hailed as a means of deploying scarce resources in the most efficient way possible. Technologies for safety, security, and the reduction of risks associated with

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<sup>29</sup> *The Care Act 2014: A guide to efficient and effective interventions for implementing the Care Act 2014 as it applies to carers* produced by the Dept of Health, ADASS, LGA, Children’s Society, Carers Trust and Carers UK, available at <http://www.local.gov.uk/documents>

falls are justified on the grounds that they can reduce hospital and nursing home admissions. Technologies can be a boon if they enable someone to remain at home but also raise questions about the individual's right to privacy and the intrusion into their homes by publicly sponsored agents. Similar debates surround the use of technological surveillance of home care workers by their employers. The use of hand-held devices and other technologies, enable employers to measure the exact amount of time each care worker spends with an individual service user. These monitoring measures provide the basis for calculating care workers' wages, the time in between appointments sometimes being judged as non-work time, or might be used to discipline them if they overstay their time at one appointment and are late for the next. They also reinforce the definition of care as a set of tasks that take a set amount of time rather than as a relationship between the care worker and the person they care for.

## Conclusion

Hochschild's observation about marketised private life highlights the particularities of precariousness at this point in history in the context of social care, which has become hyper-marketised. As Michael Sandel commented, markets are now not something we *have* but something we, as a society have *become*.<sup>30</sup> Although it is an intensely private activity, the personal care of older people has become the subject of intense public debate. It is noteworthy, however, that much of this public debate is focused on cost and on responsibility for payment. Policies are effectively distanced from actual practices of care and the commodification of care in a market system reinforces this separation. A balance sheet that portrays the hours spent on specific care tasks can be used to demonstrate efficiency in service delivery but reflects nothing of the complexity of relationships between the carer and the older person being cared for, it provides no indication of the difference that care has made to the individual's life and wellbeing and it tells us nothing about the physical and emotional effort made by individuals in the care relationship. As Keri Waerness commented, the logic of care stands in contrast to techno-rational approaches so well established in care agencies in all sectors.

This crisis in social care is a watershed moment not only for the organisation but for the fundamental principles of care, concerning mutuality, pooled risks and shared responsibility. The current crisis raises questions about who should provide care, who should pay for it and who should monitor and control the conditions under which care is provided? A deeper related question is why older people's need for social care is framed in terms of its affordability. Currently, expenditure on social care for *all* adults (of which older people's services amount to just over one half) amounts to less than 2% of GDP<sup>31</sup>. Equally importantly, according to the Audit Commission, around 15% of older people use social care services, while carers over the age of 60 provide care worth twice public spending on care. An important argument in critical gerontology is that societal ageing has provided a means of legitimating the cuts to welfare spending that were essential to the neo-liberal economic

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<sup>30</sup>Michael Sandel *What Money Can't Buy: The Moral Limits of Markets*, London, Allen Lane, 2012

<sup>31</sup> Under Pressure: Tackling the financial challenge for councils of an ageing population Local government report, The Audit Commission, London February 2010

agenda that has dominated policy-making since the 1980s<sup>32</sup>. Through this agenda welfare in general has become characterised as an *impediment to* rather than a *beneficial outcome of* prosperity. Cuts to public resources for social care are, from this perspective, a necessary political strategy irrespective of societal ageing or increased need.

Potential of care not only as a means of addressing older people's personal and practical needs (the commoditised version related to daily functioning) but also to assist in managing the many challenges we all face as a consequence of failing health in old age. It considers how care can be a central value in maintaining individual dignity and a continuing sense of self in the context of major change and challenge

A key point raised earlier in this discussion concerns the importance of distinguishing between the existential and contingent factors that influence and shape ageing.

Final point should highlight how the provision of care in later life generates precarious and vulnerable conditions, felt by all parties in caring relationships. These vulnerabilities can be related to the particular conditions of longevity that exist in contemporary British society. A long life has come to be the norm but the cultural norms and values that underpin policy-making have generated risks and vulnerabilities within the social care system.

Ward and Barnes 2016  
Waerness (in Sassoon)

the distinctive contribution of care ethics is to offer a critical take on the political dimension of care as a collective responsibility (Tronto, 2013)—on the institutional context in which care work is performed (Bowden, 1997), as well as the power relationships characterising care-giving and receiving and in understanding people in relationship to others (Barnes, 2012).

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<sup>32</sup> See for example Jan Baars 'Beyond neomodernism, antimodernism and postmodernism: basic categories for contemporary critical gerontology'. In J.Baars et al (eds) *Ageing, Globalization and Inequality: The New Critical Gerontology*. Baywood, New York, 2006.